Bedfordshire Mortality Review 2018/19

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Luton and Bedfordshire

Background

- In 2017 the Trust Board noted an increased number of serious incident reports into unexpected deaths in Bedfordshire Mental Health Services. This was associated with four unexpected deaths which led to a Care Quality Commission inspection of the service in November 2017.

- A thematic review of unexpected deaths within Bedfordshire Mental Health Services in 2017/2018 was previously presented to the Trust Board in May 2018.

- The Trust Board remains concerned about unexpected deaths within Bedfordshire Mental Health Services, as reported in the Q2 Learning From Deaths Data presented to Trust Board on 30th January 2020.

- This report covers a thematic review of unexpected deaths in Bedfordshire Mental Health Services from April 2018 to April 2019. The report cross-references national data along with action plans at Countywide and Bedfordshire, Luton, Milton Keynes Integrated Care Systam and Directorate levels.

National Context 2017-2019

(from Office for National Statistics Data released 3rd September 2019)

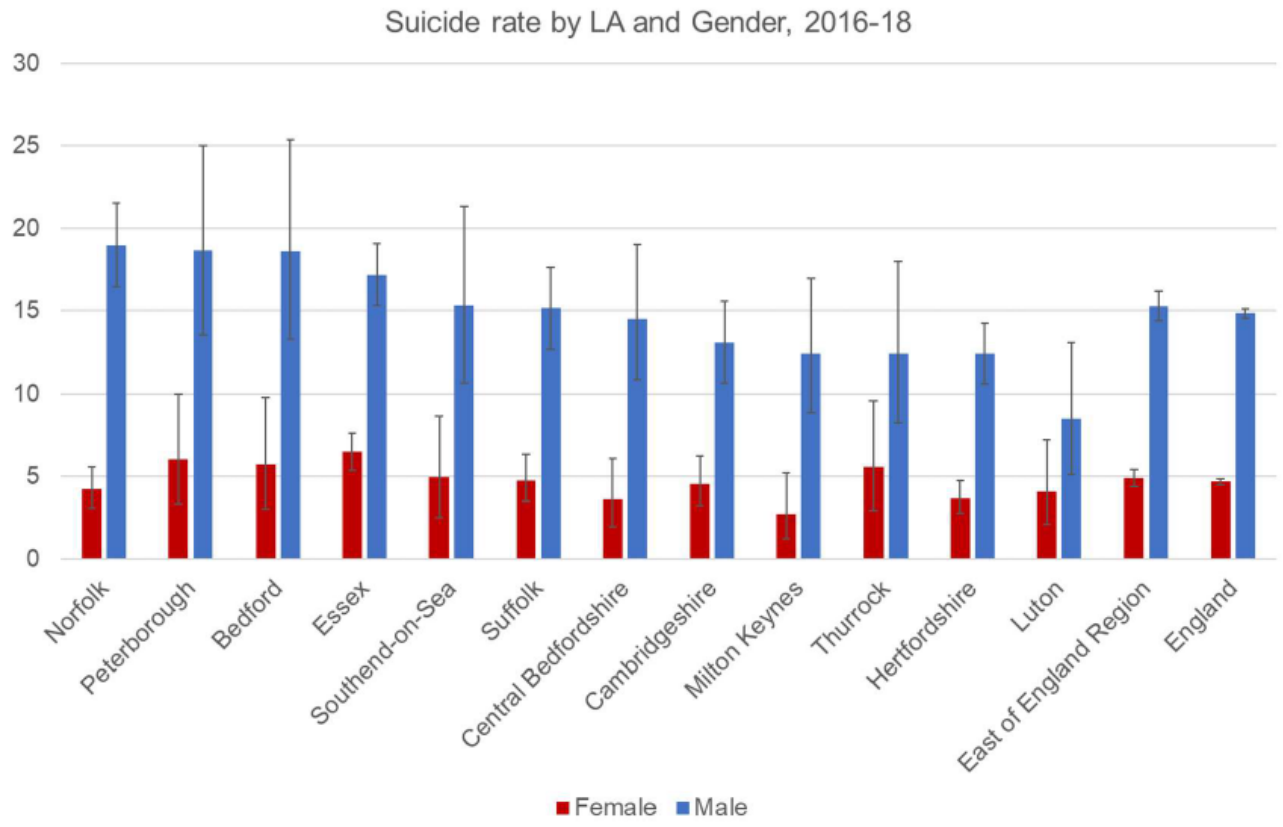
- Suicide rates decreased significantly from 1981 to 2018
- There was a statistically significant increase in suicide registrations in 2018 compared with previous year; not explained by the change in standard of proof used by coroners from July 2018:
    - England from 9.2 to 10 per 100,000 population per year
    - East of England 8.7 to 11.3

National Context

- Highest rates in males in midlife (45-49)
- Parallel increase in self-harm in males
- Links with economic factors and alcohol use
- Concerning trends in young people

Local BLMK Context

Suicide rates by LA, 2016-18



Our Bedfordshire Mental Health Services

- Community mental health teams for adults of working age and older adults in Bedford, Biggleswade, Dunstable, Houghton Regis, Leighton Buzzard
- Psychiatric liaison and crisis resolution home treatment services
- Inpatient provision
- Mental health street triage and court liaison

Bedfordshire Mental Health Services

	Caseload on clustering report	CPA caseload on clustering report	Population
Bedfordshire Directorate	7241	1154	422k
Beds and Luton countywide services (BL)	547	387	
BD +BL	**7788**	**1541**	
City and Hackney	4218	678	287k
East London MHCOP	1764	279	
Luton Directorate	2788	502	215k
Newham	3490	471	352k
Tower Hamlets	3833	542	318k

It is important to acknowledge differences in service configuration when comparing Bedfordshire and other directorates within the Trust. Relatively high numbers of individuals are accessing our MH services across Bedfordshire and this is not explained by population size alone.

Unexpected Deaths 2018/19

	Suicide	Unexpected death	All reported deaths
Male	20	5	25
Female	4	1	5
Total	24	6	30

In 2018-19 there were 29 unexpected deaths which were investigated as serious incidents (one was de-escalated)

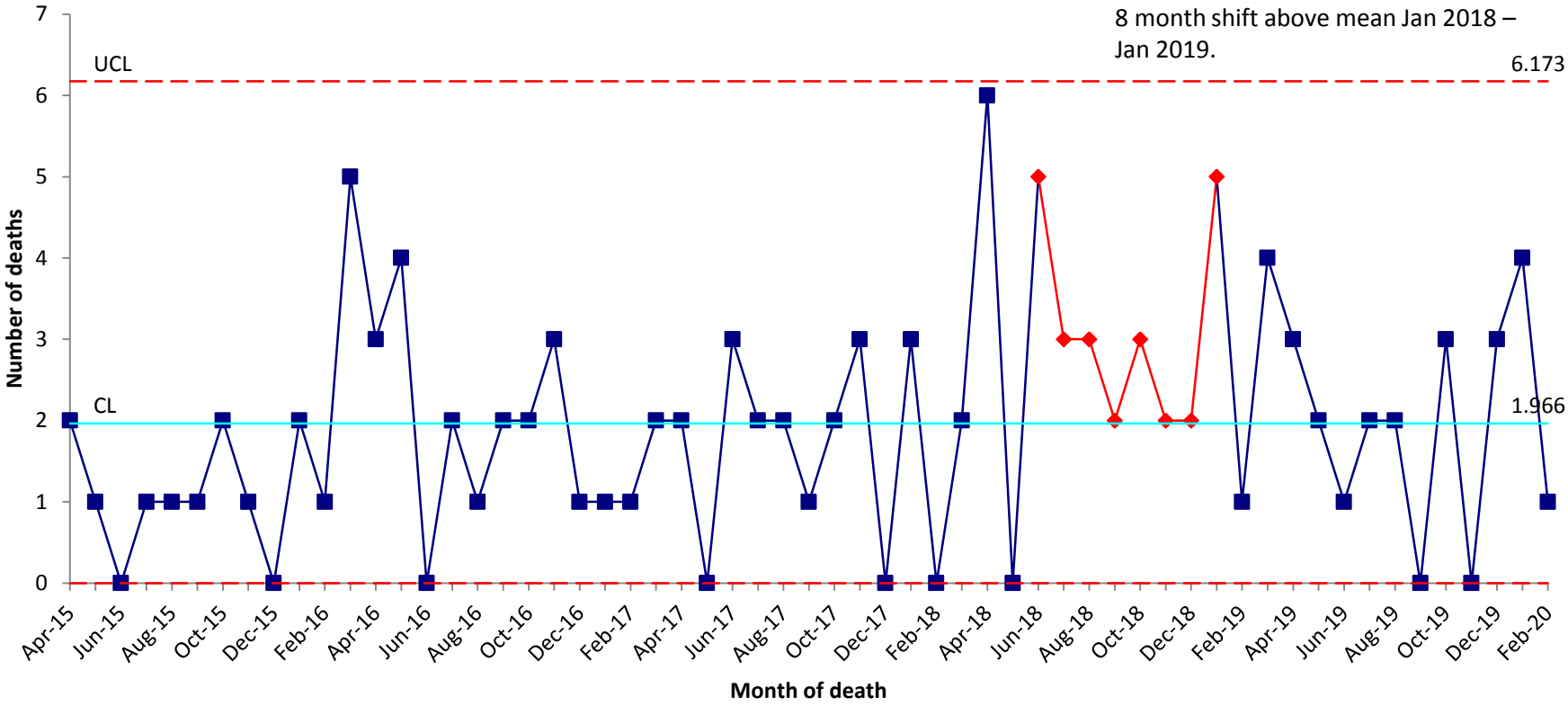
Within this period, there were 24 deaths of individuals in contact with our services, where death by suicide was suspected or confirmed.

Comparison with public health data are challenging due to different sampling periods but for an overlapping full-year period, there were 52 deaths by suicide in Bedfordshire residents.

In a 2019 sample, rates of suicide in Bedford Borough were exceeded by those in Central Bedfordshire (BBC 14 and CBC19).

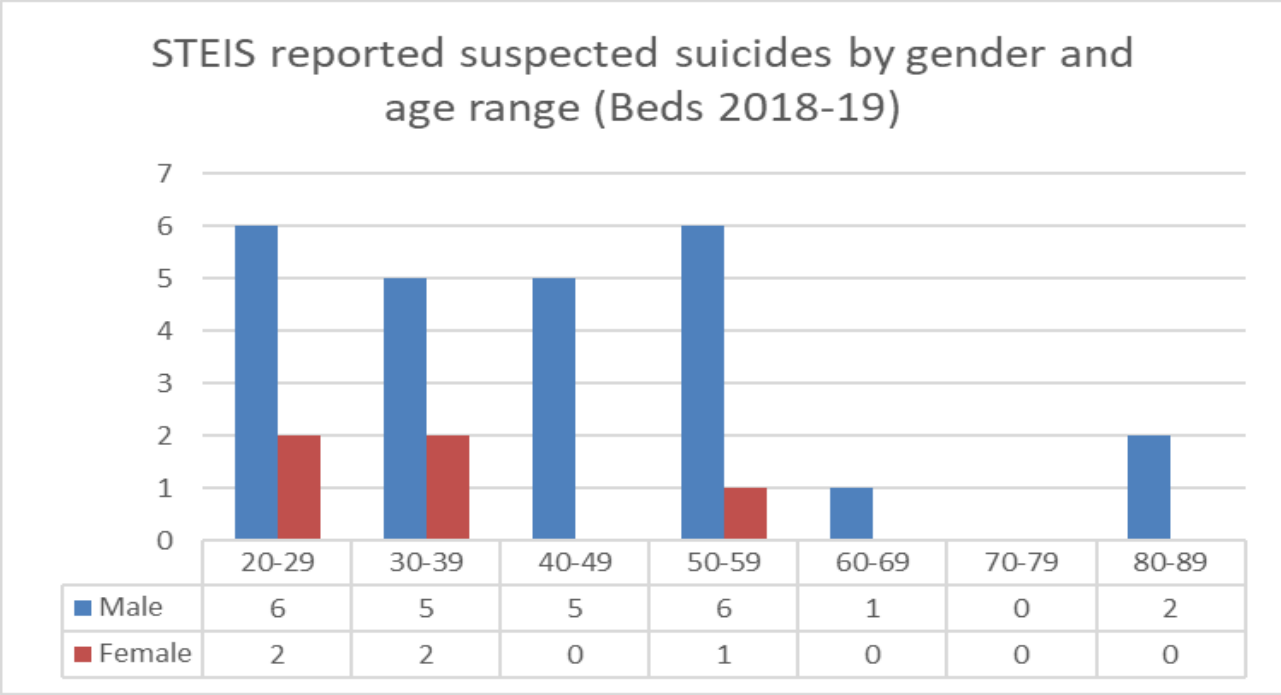
In keeping with Milton Keynes, more individuals who took their lives by suicide were in contact with mental health services (62%)as compared with the national average.

Bedfordshire Unexpected Deaths



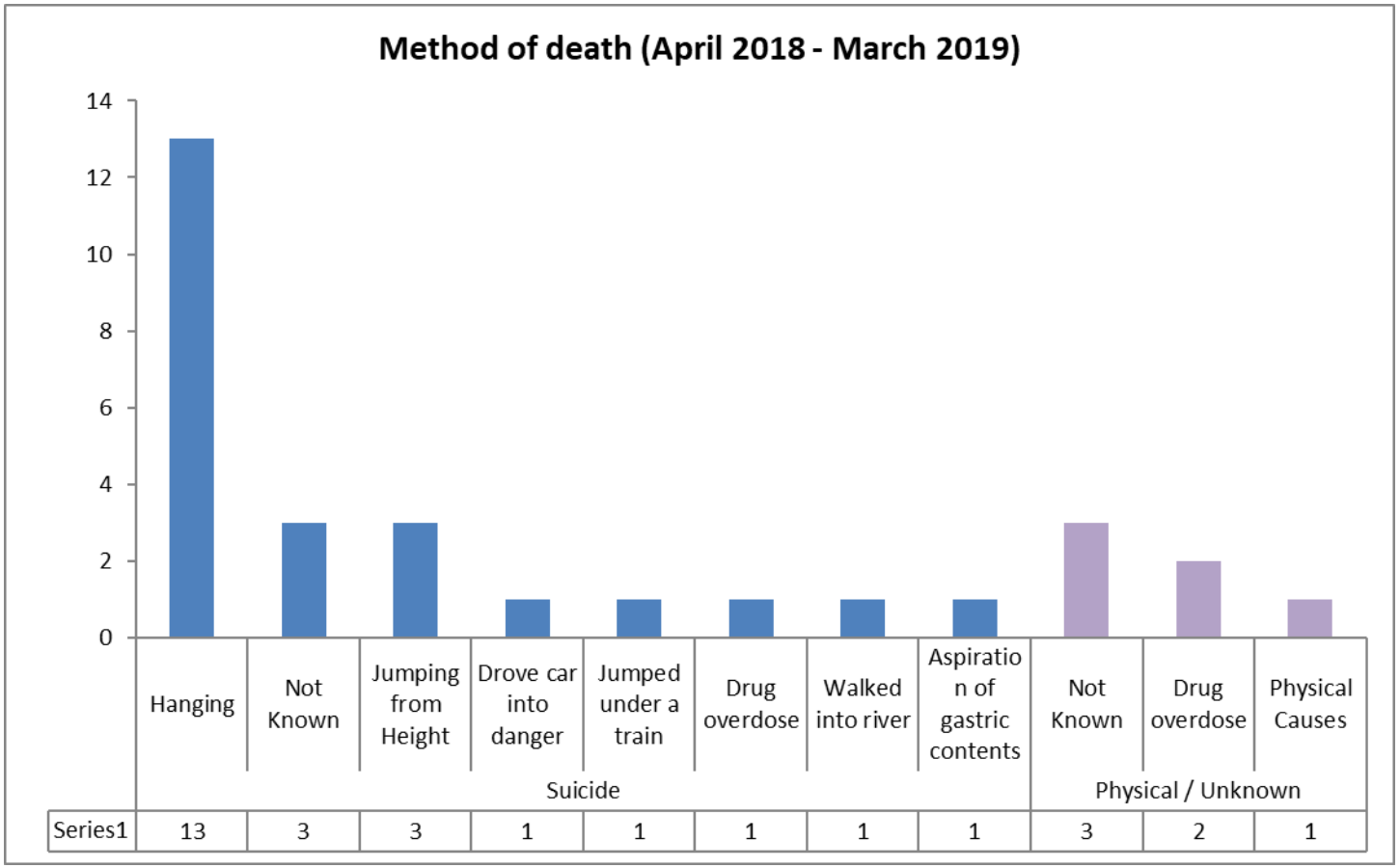
Demographics

Within the ONS 2017-2019 national data, men accounted for approximately three quarters of deaths attributed to suicide. This has been the picture since the mid-1990's.
In Bedfordshire in 2018-19 83.3% of suspected suicides were attributed to men, slightly higher than the national average.

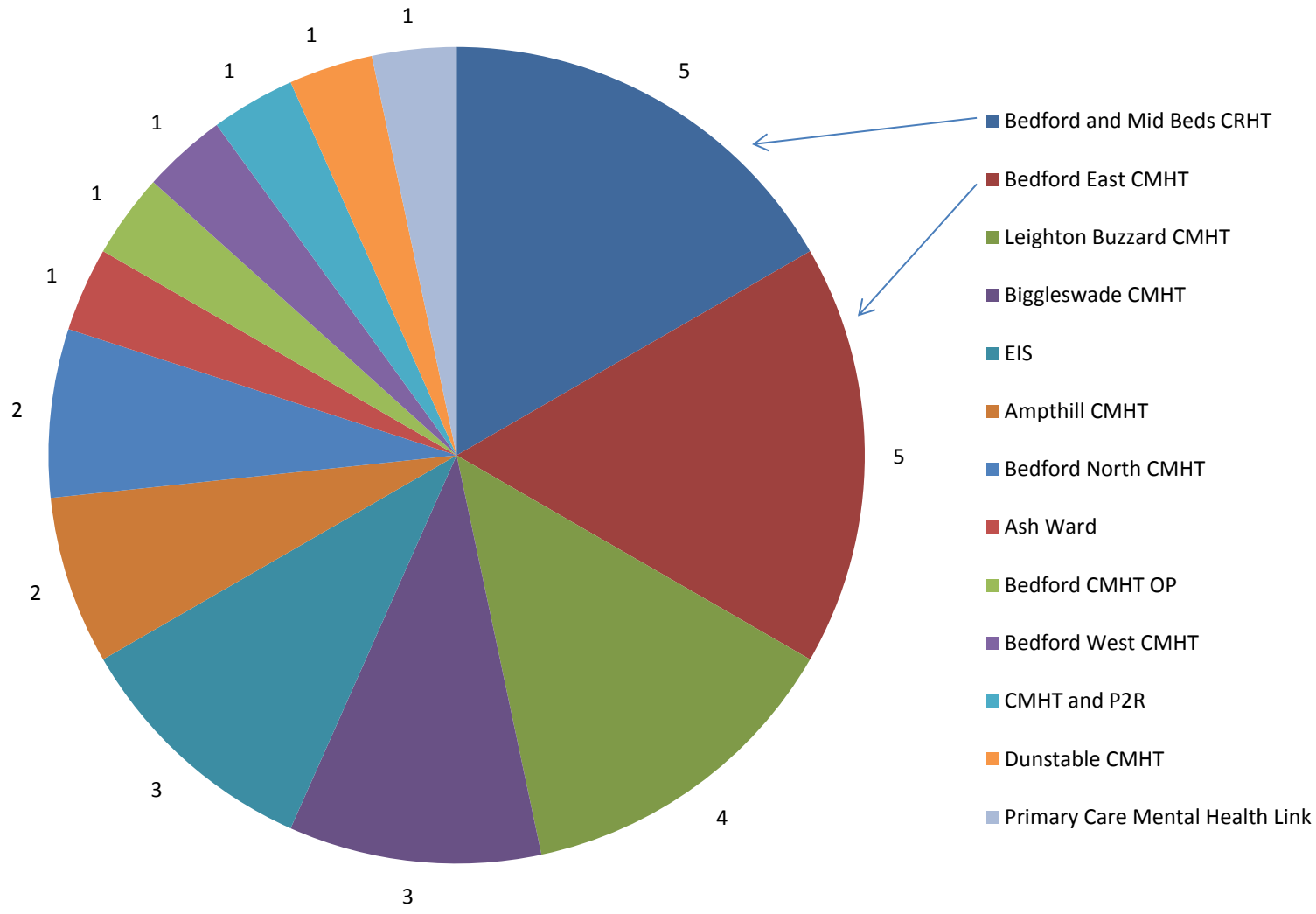


	20-29	30-39	40-49	50-59	60-69	70-79	80-89
Male	6	5	5	6	1	0	2
Female	2	2	0	1	0	0	0

Method of Death



Team


5
5
4
3
3
2
2
1
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1
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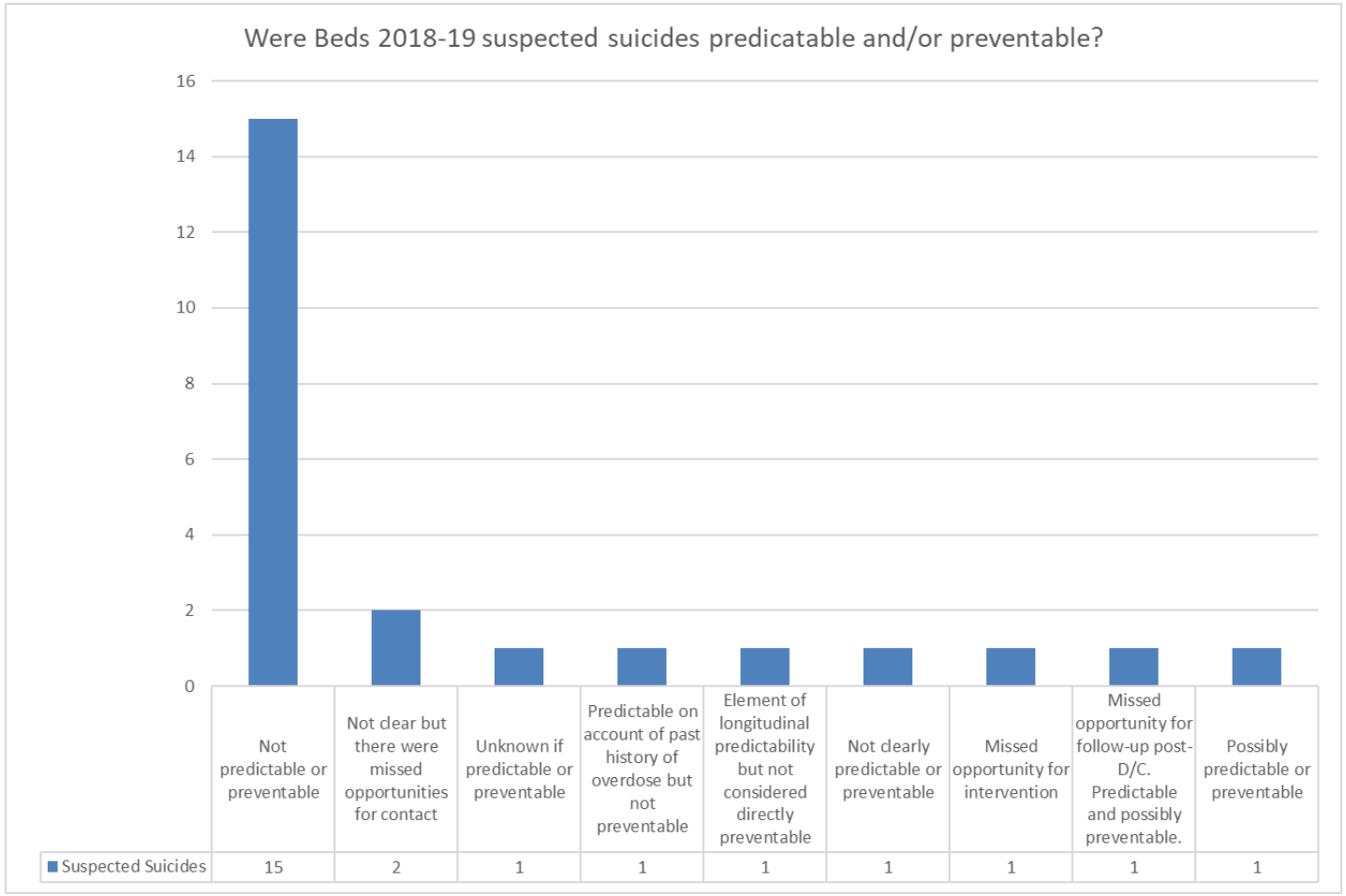
1
1
Bedford and Mid Beds CRHT
Bedford East CMHT
Leighton Buzzard CMHT
Biggleswade CMHT
EIS
Ampthill CMHT
Bedford North CMHT
Ash Ward
Bedford CMHT OP
Bedford West CMHT
CMHT and P2R
Dunstable CMHT
Primary Care Mental Health Link

Serious incident outcomes



Themes - Diagnosis

- Depression was the most common primary diagnosis with 15/30 people diagnosed with depression in some form.

- Personality disorder, schizoaffective disorder, psychotic illness and disorders associated with substance misuse also feature here. This is broadly consistent with the national picture.

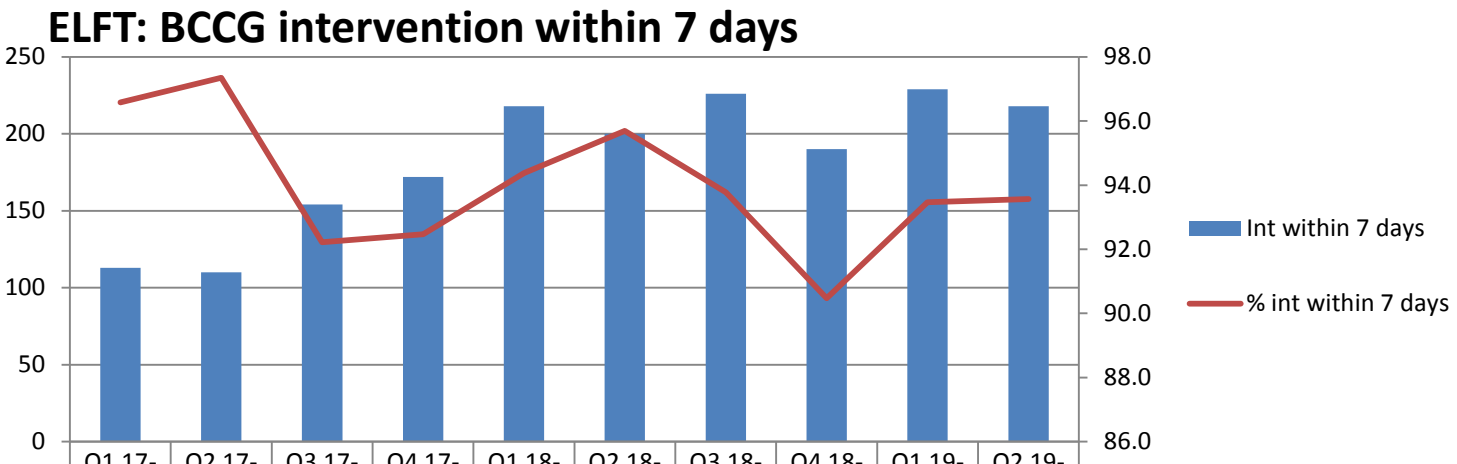
- Depression is identified as a key focus within the National Confidential Inquiry Safer Services Toolkit for suicide prevention in primary care and mental health services. 71% of individuals who due by suicide have prevented to their GP and had a diagnosis of depression.

Themes

- Problems with 72-hour follow-up
- Prevalence of substance misuse and lack of engagement with P2R or equivalent services
- Support to families and carers
- Recording of next of kin details
- Thinking of family in caring for patients
- Standards of documentation, communication of information
- Crisis care pathway communication

Actions – 72 hour follow-up

The risk of committing suicide is highest in the first three days following discharge. From March 2019 there has been a sustained shift in performance with more service users (CPA and non CPA) receiving their suicide prevention intervention within the first three days after their discharge.



	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18	Q1 18-19	Q2 18-19	Q3 18-19	Q4 18-19	Q1 19-20	Q2 19-20
Int within 7 days	113	110	154	172	218	200	226	190	229	218
% int within 7 days	96.6	97.3	92.2	92.5	94.4	95.7	93.8	90.5	93.5	93.6

Actions continued

- Connecting with People safety-plan training
- Trust-wide suicide prevention conference held in Luton July ‘19
- Compassionate services Qi work
- Thinking family Qi project Coral Ward
- Pilot model for joint working with P2R
- SLT work with PHE East of England Suicide prevention group
- Trusted assessments, 24/7 crisis teams

Actions continued

- Proposed pilot for training barbers on spot the signs
- Expansion of employment support and advice services
- Learning lessons and safeguarding staff training event March 2020
- Bedford/Florence Ball House service redesign and review of administrative process, structures
- Recruitment – reducing reliance upon agency locum staff

System Actions

- Network rail campaign
- Tall buildings work with Samaritans
- Spot the signs campaign
- Shame crime initiative
- Submissions for national funding
- Kooth, MIND
- Bereavement support
- Project on link between A+E DSH presentations and suicide